SUPREME COURT OF THE STATE OF NEVADA

TONEY A. WHITE,	)	
	)	Supreme Court No: **78483**
Appellant,	)	D.C. case no.: C-16-313216-2
	)	Dept.: **XII**
v.	)	
STATE OF NEVADA,	)	**E-filed**
	)	
Respondent.	)	
	)	

MOTION TO STAY APPELLATE PROCEEDINGS AND REMAND TO DISTRICT COURT FOR MOTION TO WITHDRAW GUILTY PLEA

Comes now the Defendant, Toney Anthony White, and moves this Honorable Court to Stay his Appeal pending in case number 78483 and remand his case to District Court so he can file a Motion to Reconsider Denial of his Motion to Withdraw his Guilty Plea based upon new evidence of his mental/medical condition at the time of his plea.

As grounds for this Motion, Defendant Toney A. White submits that his plea of guilty was involuntary and unintelligent based upon his medical conditions at the time he entered his plea. Defendant submits a review of the Defendant's medical/psychiatric history will establish that he was heavily medicated while in custody, taking anti-psychotic medicine which altered his perceptions at the time he entered his plea. (See Exhibit A, medical records from CCDC)

Wherefore, Defendant respectfully requests his case be remanded forthwith to the District Court so he can establish at an evidentiary hearing that he did not fully understand the consequences of his plea. Only after a full review of all the circumstances of the Defendant's plea can a fair decision on his case be made and his unjust conviction and sentence be corrected by allowing his plea to be withdrawn.

DATED this 6th day of August, 2019

/s/ Terrence M. Jackson

Terrence M. Jackson, Esquire
Law Office of Terrence M. Jackson
terry.jackson.esq@gmail.com
Counsel for Appellant, Toney A. White

. . .

CERTIFICATE OF SERVICE

I certify that on the 6th day of August, 2019, I served a copy of this Motion to Stay Appellate Proceeding and Remand to District Court for Withdrawal of Guilty Plea upon all counsel of record:

[X] Via Electronic Service (eFlex) to the Nevada Supreme Court;

[X] and by United States first class mail with postage affixed to the Nevada Attorney General and to the Defendant as follows:

STEVEN B. WOLFSON
Clark County District Attorney
steven.wolfson@clarkcountyda.com

STEVEN S. OWENS
Chief Deputy D.A. - Criminal
APPELLATE DIVISION
steven.owens@clarkcountyda.com

TONEY A. WHITE, ID#1214172
H.D.S.P. - P.O. Box 650
Indian Springs, NV 89070-0650

AARON D. FORD, ESQUIRE
Nevada Attorney General
100 North Carson Street
Carson City, Nevada 89701

By: */s/ Ila C. Wills*
Assistant to T. M. Jackson, Esq.

SUPREME COURT OF THE STATE OF NEVADA

TONEY A. WHITE

Supreme Court No: **78483**

Appellant

E-filed

EXHIBIT 'A'

MEDICAL RECORDS FROM CCDC

DS-9
White

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Torrey — 1/1/19
Name of Patient — Date

827090 — 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 1000mg, Haloperidol 10mg, Metamucil powder, Fluconazole 400mg, Benztropine Mesylate 1mg — cpc
cpc

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 1/1/19 2000 med pass
Date/Time

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

TONEY WHITE — Name of Patient

01/01/19 — Date

8270790 — Patient ID Number

7-19-72 — Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

STOPPED MEDS PENDING DETERMINATION OF CAUSE ON BRAIN/NASAL Fiberlax Packet 28138

erythromycin 1mg Levetiracetam 500mg Haloperidol 15mg Fluoxetine 40mg

Sertraline 50 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Toney White — Patient Signature

01/01/19 0800 — Date/Time

Witness

Witness — N Banks, LPN

NaphCare

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — Name of Patient

1/2/19 — Date

827079D 7/9/72 — Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

levetiracetam 1000mg
haloperidol 15mg
natural fiber
fluconazole 400mg
sertraline 50mg
benztropine 1mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refused
Patient Signature

1/2/19 0800
Date/Time

C9417D
Witness

D Peabody LPN
Witness

05-9
White

Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Torrey
Name of Patient

1/2/19
Date

8270790 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 1000mg, Haloperidol 10mg, Metamucil, Fluconazole 400mg
Benztropine Mesylate 1mg. CPC

CPC

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

1/2/19 2000 medpass
Date/Time

P# 7395
Witness

Witness

URGENT

JAN 01 2019

LAS VEGAS METROPOLITAN POLICE DEPARTMENT
CLARK COUNTY DETENTION CENTER

MEDICAL/DENTAL/PSYCHIATRIC REQUEST

Name: WHITE (LAST) TONEY (FIRST) ID: 8270790

Housing: 25 9 Date of Birth: 7/19/72 Date: 11/19

Description of illness or Injury: I NEED TO SEE THE DOCTOR PRONTO AS I AM IN EXTREME PAIN AND THINK I'VE CONTRACTED ABESTAS OR CONTRACTED CONDITIONS FROM MY MY MEDICATION WHICH HAVE BEEN THE REASON I STOPPED TAKING THEM. MY MUSCLES ARE DETERIORATING AND ARE EXTREMELY PAINFUL.

TO BE COMPLETED BY STAFF ONLY

Date/Time Triaged: _____ Category ☐1 ☐2 ☐3 _____RN

S: _____

O: TEMP: _____ PULSE: _____ RESP: _____ BP: _____

Appointment Scheduled with Psych Provider

A: _____

B: _____

Refer To: ☐ Sick Call Doctor ☐ Nurse ☐ Psychiatrist ☑ Dentist ☐ DON ☐ Other: _____

Fee Charge: ☐ $ 8.00 Medical Access Fee ☐ $5.00 Medication Fee ☐ $3.00 Medication Renewal Fee
☐ $200.00 or actual cost whichever is higher ☑ No Charge

I understand pursuant to NRS 211.140 that I may be responsible for payment for medical care (see back of this form).

I understand that a Medical Access Fee and/or Medication Fee will be deducted from my cash account.

I understand that fees may be collected at a later date if funds are not currently available. If I do not have sufficient funds to pay and money is deposited to my cash account, the amount I owe for these services will be deducted before any funds are available to me. No inmate will be refused in-house medical services based upon an inability to pay at the time the healthcare is provided.

Inmate Signature: _____ Date: 01/01/19

Staff Signature: _____ Date: 1/2/19 Time: 0545

INMATE NAME (please print)	ID#:	HOUSING:
TONEY WHITE	8270790	25-9

DISTRIBUTION: WHITE - Medical Records YELLOW - Inmate

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Jessey Anthony — Name of Patient

11/3/19 — Date

827D790 — Patient ID Number

7/8/1972 — Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Keppra 1000, Haloperidol 10, metamucil 1pack, Fluconazole 400mg

Benztropine Mesylate 1mg. CPC

CPC

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

11/3/19 2000 med pass

Date/Time

Witness

Witness

RELIGIOUS DIET ORDER

1-3-19
DIET START DATE

Release
DIET END DATE

Tony White
INMATE'S NAME

827079
INMATE'S ID NUMBER

2-D-9
INMATE'S LOCATION

☐	PORK FREE RELIGIOUS DIET
☐	LACTO-OVO VEGETARIAN
☐	TOTAL VEGETARIAN (VEGAN)
☒	OTHER Kosher / Halal

Bonnie Polley
AUTHORIZED SIGNATURE

1-3-19
DATE REQUESTED

ARAMARK
Correctional Services

2J-09

TSF
1/4/19

LAS VEGAS METROPOLITAN POLICE DEPARTMENT
CLARK COUNTY DETENTION CENTER

MEDICAL/DENTAL/PSYCHIATRIC REQUEST

Name: WHITE (LAST) TONEY (FIRST) ID: 8270790

Housing: 2J-9 Date of Birth: 7/19/72 Date: 1/4/19

Description of Illness or Injury: PLEASE CHARGE MY ACCOUNT AND ORDER THAT I BE WEIGHED.

TO BE COMPLETED BY STAFF ONLY

Date/Time Triaged: _____ Category ☐1 ☐2 ☐3 _____ RN

S: _____

O: TEMP: _____ PULSE: _____ RESP: _____ BP: _____

Weight check ordered

A: _____

B: _____

Refer To: ☐ Sick Call Doctor ☐ Nurse ☐ Psychiatrist ☐ Dentist ☐ DON ☐ Other: _____

Fee Charge: ☑ $ 8.00 Medical Access Fee ☐ $5.00 Medication Fee ☐ $3.00 Medication Renewal Fee
☐ $200.00 or actual cost whichever is higher ☐ No Charge

I understand pursuant to NRS 211.140 that I may be responsible for payment for medical care (see back of this form).

I understand that a Medical Access Fee and/or Medication Fee will be deducted from my cash account.

I understand that fees may be collected at a later date if funds are not currently available. If I do not have sufficient funds to pay and money is deposited to my cash account, the amount I owe for these services will be deducted before any funds are available to me. No inmate will be refused in-house medical services based upon an inability to pay at the time the healthcare is provided.

Inmate Signature: _____ Date: 1/4/19

Staff Signature: _____ Date: 1/5/19 Time: 8:19

INMATE NAME (please print)	ID#:	HOUSING:
TONEY WHITE	8270790	2J-9

DISTRIBUTION: WHITE - Medical Records YELLOW - Inmate

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Torrey Anthony — 1/4/19

Name of Patient — Date

8270790

8270790 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 1000mg, Haloperidol 10mg, Natural Fiber, Fluconazole 400mg, Benztropine Mesylate 1mg — CPC

CPC

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

1/4/19 2000 med pass

Date/Time

T16710B

Witness

Witness

URGENT

LAS VEGAS METROPOLITAN POLICE DEPARTMENT
CLARK COUNTY DETENTION CENTER

MEDICAL/DENTAL/~~PSYCHIATRIC~~ REQUEST

Name: WHITE (LAST) TONEY (FIRST) ID: 8270790

Housing: 2J-09 Date of Birth: 7/19/72 Date: 01/04/19

Description of Illness or Injury: I NEED TO TALK TO THE SOCIAL WORKER PSYCHOLOGIST ABOUT CONTINUING THOUGHTS OF SELF HARM AND WORTHLESSNESS AND TO DISCUSS MY TREATMENT LEVEL.

TO BE COMPLETED BY STAFF ONLY

Date/Time Triaged: _____ Category ☐1 ☐2 ☐3 _____ RN

S: _____

O: TEMP: _____ PULSE: _____ RESP: _____ BP: _____

A: Patient concerned about housing wanting to be transferred to psych housing. Patient informed that this is a close custody due to the fact that he is a Max inmate.

B: Patient advised to file psych slip if needed, also to inform an officer of SI/HI.

Refer To: ☐ Sick Call Doctor ☐ Nurse ☐ Psychiatrist ☐ Dentist ☐ DON ☐ Other: _____

Fee Charge: ☐ $ 8.00 Medical Access Fee ☐ $5.00 Medication Fee ☐ $3.00 Medication Renewal Fee
☐ $200.00 or actual cost whichever is higher ☐ No Charge

I understand pursuant to NRS 211.140 that I may be responsible for payment for medical care (see back of this form).

I understand that a Medical Access Fee and/or Medication Fee will be deducted from my cash account.

I understand that fees may be collected at a later date if funds are not currently available. If I do not have sufficient funds to pay and money is deposited to my cash account, the amount I owe for these services will be deducted before any funds are available to me. No inmate will be refused in-house medical services based upon an inability to pay at the time the healthcare is provided.

Inmate Signature: _____ Date: 01/4/19

Staff Signature: _____ Date: 1/4/19 Time: 1510

INMATE NAME (please print)	ID#:	HOUSING:
TONEY WHITE	8270790	2J-9

DISTRIBUTION: WHITE - Medical Records YELLOW - Inmate

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tommy Anthony — 11/5/19

Name of Patient — Date

8270790 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 1000, Haloperidol 10mg, Metamucil Powder — CPC

Fluconazole 400, Benztropine Mesylate 1mg — CPC

— CPC

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 11/5/19 2000 med pass

Date/Time

Witness — 11/5/2

Witness — CPC

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 1/6/19

Name of Patient — Date

827.798 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 500mg, HALOPERIDOL 1mg, METAMUCIL, FLUCONAZOLE 150mg, CEFTRIN 1mg.

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

Witness 1/6/19 — MOHAMMAD, LPN

Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 1/7/19

Name of Patient — Date

8270790 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000 mg, HALOPERIDOL 5 mg, METAMUCIL, FLUCONAZOLE 400 mg, COLCHICIN 1 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

A. WILLIAMS 14524 — MOHMLAD, LPN

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — Name of Patient

1/10/19 — Date

8270790 — Patient ID Number

7/19/72 — Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

levetiracetam 1000mg
haloperidol 15mg
natural fiber
fluconazole 400mg
sertraline 50mg
benztropine 1mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refused — Patient Signature

1/10/19 0800 — Date/Time

Witness

Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — 1/12/19

Name of Patient — Date

8270790 — 7/19/72

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

levetiracetam 1000mg — sertraline 50mg

haloperidol 15mg — benztropine 1mg

natural fiber

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refused — 1/12/19 0800

Patient Signature — Date/Time

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Tonéy White — 01/19/2019

Name of Patient — Date

8270790 — 07/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg Tab, Fluoxetine 200mg Tab
Haloperidol 5mg Tab, Sertraline HCL 50mg, Benzotropine ~~Mesylate~~ QDS Mesylate Oral 1mg
Natural Fiber Laxative Oral 28.3% Powder

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 01/19/2019 0800 — Date/Time

Witness 8237 — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White Tommy, Anthony
Name of Patient

1/19/19
Date

8270790 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 1000mg, Haloperidol 10mg, Benztropine Mesylate 1mg
Natural Fiber Powder, Glucosamine 400mg — QR
— CPC

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

1/19/19 2000 midpass
Date/Time

Witness

Witness

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#25-09

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tommy Anthony — 1/25/2019

Name of Patient — Date

8270790 / 07/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg Tab — Mineral Oil Light Laxative Heal 28.3% Powder

Haloperidol 10 mg Tabs — Fluconazole 200mg Tab

Benztropine Mesylate 1mg Tab

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 01/25/2019 2000

Patient Signature — Date/Time

T128GL — [illegible]

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — 1/20/19

Name of Patient — Date

82-10790 — 7/19/72

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

levetiracetam 1000mg	Sertraline 50mg
haloperidol 15mg	natural fiber
benztropine 1mg	fluconazole 400mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refusal — 1/20/19 0800

Patient Signature — Date/Time

[signature] 9222 — [signature] LPN

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 1/29/19

Name of Patient — Date

827-790 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000 mg, HALOPERIDOL 10 mg, COGENTIN 1 mg, METAMUCIL, FLUCONAZOLE 400 mg.

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

[signature] 13850 — Witness

[illegible], LPN — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — 1/30/19

Name of Patient — Date

8270190 — 7/9/72

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

levetiracetam 1000mg — sertraline 50mg

haloperidol 15mg — natural laxative

benztropine 1mg — fluconazole 400mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refused — 1/30/19 0800

Patient Signature — Date/Time

Witness — Witness

NaphCare
Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — 1/31/19
Name of Patient — Date

8270790 — 7/19/72
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

levetiracetam 1000mg — sertraline 50mg
haloperidol 15mg — natural fiber
benztropine 1mg — fluconazole 400mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refused — 1/31/19 0800
Patient Signature — Date/Time

Witness — Witness

Clark County Detention Center
330 S. Casino Center Blvd.
Las Vegas, NV 89101
702-671-5698

1/29/2019 2:01:51 PM Pacific Standard Time

MAR

PICTURE NOT AVAILABLE

Patient:	WHITE, TONEY ANTHONY	**#:**	08270790	**Lang:**	
DOB:	7/19/1972 (Age=46)	**Sex:**	M	**Race:**	B
Housing:	LVMPD-ST-2J-09-S	**SSN:**	**HIDDEN**	**Type:**	
Status:	ACTIVE	**Booking Date:**	2/3/2016 12:00:00 AM Pacific Standard Time	**Release:**	

Allergies: Carbamazepine, Depakote, Dilantin, Phenobarbital

Name	Directions	Start	Stop	Provider Name	Placed By	Additional Information	Date Created	Discontinued By	Discontinued Date	Discontinued Reason
LevETIRAcetam Oral 500 MG Tablet	Take 1000 mg by mouth twice a day for 90 day(s).	12/19/2018	3/18/2019 11:59 PM Pacific Daylight Time	MARTINEAU, KYLE PA	Daryl Phillips RN		12/19/2018 9:25 AM Pacific Standard Time			
Haloperidol Oral 5 MG Tablet	Take 15 mg by mouth once in the morning for 90 day (s). *for AVH.	12/15/2018 8:00 AM Pacific Standard Time	3/14/2019 11:59 PM Pacific Daylight Time	FISHER, TERRI NP	Terri Fisher NP	for AVH	12/15/2018 4:52 PM Pacific Standard Time			
Haloperidol Oral 10 MG Tablet	Take 10 mg by mouth once before bedtime for 90 day (s). *for AVH.	12/15/2018 8:00 PM Pacific Standard Time	3/14/2019 11:59 PM Pacific Daylight Time	FISHER, TERRI NP	Terri Fisher NP	for AVH	12/15/2018 4:51 PM Pacific Standard Time			
Benztropine Mesylate Oral 1 MG Tablet	Take 1 mg by mouth twice a day for 90 day(s).	1/20/2019	4/19/2019 11:59 PM Pacific Daylight Time	FISHER, TERRI NP	Terri Fisher NP		12/15/2018 4:51 PM Pacific Standard Time			

Name	Directions	Start	Stop	Provider Name	Placed By	Additional Information	Date Created	Discontinued By	Discontinued Date	Discontinued Reason
Sertraline HCl Oral 50 MG Tablet	Take 50 mg by mouth once in the morning for 90 day (s).	1/20/2019	4/19/2019 11:59 PM Pacific Daylight Time	FISHER, TERRI NP	Terri Fisher NP		12/15/2018 4:50 PM Pacific Standard Time			
Natural Fiber Laxative Oral 28.3 % Powder	Take 1 by mouth twice a day for 90 day(s).	11/21/2018	2/18/2019 11:59 PM Pacific Standard Time	MARTINEAU, KYLE PA	Scott Blondeaux Charge RN		11/21/2018 11:47 AM Pacific Standard Time			
Fluconazole Oral 200 MG Tablet	Take 400 mg by mouth twice a day for 90 day(s).	11/21/2018	2/18/2019 11:59 PM Pacific Standard Time	MARTINEAU, KYLE PA	Kyle Martineau PA		11/16/2018 11:52 AM Pacific Standard Time			
Lower Bunk	once before bedtime HS	3/1/2018	2/28/2019 11:59 PM Pacific Standard Time	WILLIAMSON, LARRY MD	Camisha Gathright LPN		3/1/2018 8:32 AM Pacific Standard Time			

STEINBERG DIAGNOSTIC MEDICAL IMAGING CENTERS

Phone: (702) 732-6000 www.sdmi-lv.com Fax: (702) 732-6071

Patient: Toney White
SDMI #: 1614330
Pt. DOB: 07/19/1972
Pt. Sex: Male
Date of Service: 12/14/18
SDMI Location: NW

Physician: Kyle Martineau PA-C
Dr. Fax: (702) 366-0576
Dr. Phone: (702) 671-5698
Dr. Addr.: 330 S Casino Center Blvd Las Vegas, NV 89101
Cc:
Cc:

MRI BRAIN WITH AND WITHOUT CONTRAST

CLINICAL HISTORY:
Seizure disorder.

TECHNIQUE:
Sagittal T1, Axial T2, Axial FLAIR, . Axial and coronal T1 post gadolinium. 10 cc's IV dotarem administered.

COMPARISON:
No significant change compared with May 2018

FINDINGS:
Favor moderate supratentorial small vessel ischemic change advanced for age. No change in numerous bilateral fairly symmetrical subcentimeter supratentorial white matter abnormalities. Largely subcortical and deep white. No individual focus or pattern that would implicate demyelinating disease/MS based on the MRI. Correlate with neurologic exam. No mass. Large vessel flow voids are patent. There is no restricted diffusion.

IMPRESSION:
No significant change. Favor moderate supratentorial small vessel ischemic change advanced for age

Interpreted by: David Browne 12/14/2018 1:25 PM

Electronically approved by: David Browne, M.D. Date: 12/14/18 13:55

Clark County Detention Center
330 S. Casino Center Blvd.
Las Vegas, NV 89101
702-671-5698

1/29/2019 1:55:03 PM Pacific Standard Time

Offsite Healthcare Authorization

This section to be completed by NaphCare Staff - Approval Number - TC161101

1) Inmate's Name (Last, First Middle Initial)	2) Inmate's ID Number	3) Date of Birth
WHITE, TONEY A	**08270790**	**7/19/1972**
4) Social Security Number	5) Gender	6) Book Date / Release Date
	M	**2/3/2016 /**
7) Responsible Party		Electronically signed by
Reprice by NaphCare		**MARTINEAU, KYLE (1235676610)**
		12/18/2018 1:53:25 PM

8) Reason
F/U after MRI of brain

9) Allergies
Carbamazepine, Depakote, Dilantin, Phenobarbital

10) Order
DR. KEVIN XIE 3006 S. MARYLAND PKWY STE 765, 7TH FLOOR LAS VEGAS, NV 89109 P 702.731.8115

11) Transportation Type
Unknown

12) History of Present Illness / Current Symptoms / Current Treatments / Medications
LevETIRAcetam Oral 500 MG Tablet, Haloperidol Oral 5 MG Tablet, Haloperidol Oral 10 MG Tablet, Benztropine Mesylate Oral 1 MG Tablet, Sertraline HCl Oral 50 MG Tablet, Natural Fiber Laxative Oral 28.3 % Powder, Fluconazole Oral 200 MG Tablet, Lower Bunk

Asthma, Seizure Disorder

13) Type Requested (E.G. Cardiology, Surgical Consult, CT/MRI)
Neurology

14) Details

15) Name of Facility / Physician Where Services Requested
PLACECARD PROVIDER

16) Service Date
1/30/2019 11:00:00 AM

17) Facility / Physician Address
DR. KEVIN XIE 3006 S. MARYLAND PKWY STE 765, 7TH FLOOR LAS VEGAS, NV 89109 P 702.731.8115

Instructions to Off Site Providers

1. NaphCare will not be financially responsible for any non-emergency treatments that are not directly related to the diagnosis printed on this form. To obtain authorization for additional treatments, you must contact NaphCare Utilization Approval by calling (205) 536-8400 or (800) 834-2420 ext. 8695.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete the bottom portion of this form, place it in a sealed envelope, and give to the Correctional Officer when the inmate is returned.
4. Use the Inmate's I.D. Number as the Insured I.D. Number on claim forms.

This section to be completed by off site provider

Findings

Medication Changes

Recommendations

1) lab
2) Aspirin 81 mg daily
3) continue all other meds
4) See Dr xie in 3M

Provider's Signature:

Date 1/30/19

1/30/19

Kevin Xie, MD, PHD, MBA, Neurologist, Epileptologist

Board Certified in Adult Neurology and Epilepsy

Nevada Neuroscience Institute

Sunrise Hospital & Medical Center

3006 Maryland Parkway, Suite 765 Las Vegas, NV 89109

Phone: 702-961-7310; Fax: 844-231-4920

See my assistant before you leave the clinic and keep this sheet for your record

Old record, Old CT or MRI film and report, EEG report,

Patient agreement form, Urine drug screen, PDMP

CT, MRI/MRA/MRV, Pet, Wada, DATSCAN, US

EEG (routine), Sunrise Hospital Inpatient EEG Monitoring (Dr. Xie)

EMG, Here at Dr. Xie's Clinic, LAB.

Referral,

PT, OT, Speech, Dietitian Neuropsychology test
National registry for women with epilepsy and pregnancy, CBD oil

VNS for epilepsy, Neuropace for epilepsy, Cefaly for migraine/Headache, Eneura Spring TMS for migraine, DBS for tremor and PD Wrist splint. DMV form. Letter.

Trigger point injection, Occipital nerve block, Botox injection Preauthorization

Continue all medications

New Medication: baby Aspirin

Next Office visit: 3 M

To view your test results, please sign in patient portal of our EMR system (ECW). The results will be available as soon as physicians review them. Otherwise, they are also available on next office visit. You **will not** receive notification in the mail.

8-10 hrs fasting

Order Form

385711NN1 NV NEUROSCIENCES INST
3006 S MARYLAND PKWY, STE 765
LAS VEGAS, NV, 891092246
702-961-7310 844-231-4920

Req/Ctrl# (CD-): 318138811
KEVIN C XIE, MD
NPI: 1700868155
Neurology

White, Toney, Male, 07/19/1972 ID: 8X301694482
702-671-5698 330 S CASINO CENTER BLVD, LAS VEGAS, NV, US 89101-6102

Today: 01/30/2019 12:21 PM
Order Date: 01/30/2019 11:00 AM

Primary Insurance Name: NAPHCARE INC
Insurance Address: 2090 COLUMBIANA RD STE 4000 , BIRMINGHAM , AL , 352162158
Subscriber Number: TC142286
Insured Name: White, Toney
Address: 330 S CASINO CENTER BLVD, LAS VEGAS, NV, US 89101-6102

Priority	Lab	Fast	Source/Coll Date and Time	Assessment(s)	Clinical Info
Routine	LEVETIRACETAM (QLV-15142X)	No		- G40.909, Seizure disorder	
Routine	LIPID PANEL (80061)	No		- G40.909, Seizure disorder	
Routine	Oxcarbazepine (Trileptal),S (L-716928)	No		- G40.909, Seizure disorder	

Electronically Signed By:
KEVIN C XIE, MD

Signature of Patient/Guardian

DATE	TIME	INAMTE	HOUSING	ADDRESS
WED 1/30	11:00 AM EST 1 ✓	WHITE, TONEY #08270790 7/19/1972 ✓ MAX/PC	-ST -2J -09	DR. KEVIN XIE 3006 S. MARYLAND PKWY STE 765, 7TH FLOOR LAS VEGAS, NV 89109 ✓ P 702.731.8115

SPECIALTY: NEURO	**ROUTINE**
SCHEDULED WITH: JORDAN	**CONFIRMED WITH:** Sharon

OFFSITE NOTES:

Asprin Ordered

PLEASE DO NOT SHARE ANY FUTURE APPOINTMENTS WITH THE PATIENT

PLEASE RETURN PACKET TO:

NORTH TOWER THIRD FLOOR MEDICAL ADMIN OFFICE.

FOR OFFICER USE ONLY

CIRCLE ONE: **COMPLETED** **REFUSED** **RELEASED** **OTHER**

REASON IF APPT IS NOT COMPLETED: _____

SIGN: _____ **DATE:** 1-30-19

INMATE SIGNATURE FOR REFUSAL: _____

CALL (*702)671-5698* FOR ANY OTHER INFORMATION

NaphCare

Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/9/19

Name of Patient — Date

827079 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

FLUCONAZOLE 400mg, METAMUCIL, KEPPRA 1000mg, COGENTIN 1mg, HALDOL 10mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

13604 — MOHAMMAD, LPN

Witness — Witness

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Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/5/19
Name of Patient — Date

827-790 — 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

FLUCONAZOLE 400 mg, METAMUCIL, GABAPIN 1 mg, HALDOL 10 mg, KEPPRA 1000 mg.

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

12606 — MDUMUNDO, LPN

Witness — Witness

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Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/6/19
Name of Patient — Date

827090 — 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

FLUCONAZOLE 400mg, METAMUCIL, COLENTIN 1mg, HALDOL 10mg, KEPPRA 1000mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

Toney White — 2/1/19
Name of Patient — Date

821070790 — 7/19/72
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

asperun 81mg — benztropine 1mg — fluconazole 400mg
levetiracetam 1000mg — Setraline 50mg
haloperidol 15mg — natural fiber

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

refused — 2/1/19 0800
Patient Signature — Date/Time

[illegible] — [illegible] LPN
Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Teodoro — 2-7-19
Name of Patient — Date

$270790 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg Tab, Haloperidol 10mg Tablet, Benztropine Mesylate 1mg Tablet, Salmeterol Fluticasone Inhalation 28.3% Powder, Fluconazole 200mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 2/7/19 2000
Patient Signature — Date/Time

Witness — Witness

#9

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tonay — 2-8-2019
Name of Patient — Date

8270790 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500 mg Tablet; Natural Fiber
Haloperidol 10mg Tablet; Fluoxymesterone 200mg Tablet
Benztropine Mesylate 1mg Tab

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 2-8-2019 / 2000
Patient Signature — Date/Time

AH7114B — [illegible]
Witness — Witness

LJ

NaphCare
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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White Tanay
Name of Patient

2 9 2019
Date

827 0790 7 19 1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500 mg Tab Haloperidol 10 mg Tab
Benztropine Mesylate 1 mg Tab Natural Fibre 28.3% Powder
Thiamine 100 mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

2-9-2019
Date/Time

Witness

Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/10/19
Name of Patient — Date

8270790 — 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000 mg, HALDOL 10 mg, GEODON 10 mg, INTRAMUSCULAR; FLUCONAZOLE 400 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

J. GARCIA 17107 — MONTANA, CPT

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — Name of Patient

2/10/19 — Date

8270790 7/19/1972 — Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000 mg, HALDOL 10 mg, ROCEPHIN 1mg, INTRAMUSCULAR, FLUCONAZOLE 400 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

Date/Time

J. GARCIA 17107
Witness

MONTANA, CPT
Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONY | 2/11/19
Name of Patient | Date

8270790 7/16/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000mg, HALDOL 10mg, COGENTIN 1mg, METAMUCIL, FLUCONAZOLE 400mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature | Date/Time

Witness | Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONY — 2/12/19
Name of Patient — Date

B270790 — 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000mg, HALDOL 10mg, METAMUCIL, COGENTIN 1mg, FLUCONAZOLE 400mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

BUENO PHA (710) — MOUMIVO, LPN

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tawny — 02-13-2019

Name of Patient — Date

8270790 / 07/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500 mg Tablet, Haloperidol 10 mg Tablet, Benztropine 1 mg Tablet, Natural Fiber Laxative Oral 28.3% Powder, Fluoxetine 200 mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 02/13/2019 / 2000

Patient Signature — Date/Time

M.G/M 0620 — Witness

Witness

NaphCare

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tawny — Name of Patient

2-14-2019 — Date

8270790 / 07-19-1972 — Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg — Ibuprofen 800mg Tablet

Hydroxizine 10mg Tablet — Fluconazole 200mg Tablet

Bacitracin 10mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — Patient Signature

2-14-19 / 2000 — Date/Time

MSU 922 S — Witness

Witness

ZJ-9

NaphCare
Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tenery
Name of Patient

2-16-2019
Date

8270790 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500 mg, Haloperidol 1.0 mg Tablet,
Benztropine Mesylate 1mg Tab Fluconazole 200 mg Tab
Duricef Fibers 28.3% Powder

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused
Patient Signature

2-16-2019 / 2000
Date/Time

S88611C
Witness

Witness

NaphCare
Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY

Name of Patient

2/17/19

Date

827-790 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000mg, METAMUCIL, COGENTIN 1mg, HALDOL 10mg, FLUCONAZOLE 400mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

Date/Time

D[illegible]

Witness

[illegible], LPN

Witness

NaphCare

Your independent health care choice.

RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/18/19

Name of Patient — Date

827090 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

FEPPRA 1000mg, HALDOL 5mg, CEFTRIN 1mg, METAMUCIL, FLUOXETINE 40mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

13850 — MORRISON, LPN

Witness — Witness

2I9

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tonisy — 2-19-2019
Name of Patient — Date

827090 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg Tablet, Haloperidol 10mg Tablet, Benztropine Mesylate 1mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 2-19-2019 / 2000
Patient Signature — Date/Time

13852 — —
Witness — Witness

25-9

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tandera — 2-20-2019
Name of Patient — Date

~~M~~ 827079 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Aspirin 81mg, Levothyroxine 50Mcg Tab, Haloperidol 5mg Tab, Benztropine Mesylate 1mg Tab, Lisinopril 50Mg Tab

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 2-20-19 / 0424 - 02-20-19 / 0424 Date/Time

R9273 H
Witness

Witness

NaphCare

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/21/19

Name of Patient — Date

827096 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

ASPIRIN 81mg, KEPPRA 1000mg, HALDOL 1mg, COGENIN 1mg, ZOLOFT 50mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

13850 — MOHAMMAD, LPN

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/22/19
Name of Patient — Date

B2710790 / 7/19/72
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

ASA 81 MG, KEPPRA 1000 MG, HALDOL 5 MG,
BENZTROPINE 1MG, ZOLOFT 50 MG

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

REFUSED — 2/22/19 0700
Patient Signature — Date/Time

9895 — RN LPN
Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 2/26/19

Name of Patient — Date

827590 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1000 mg, HALDOL 5 mg, ZOSYN 1 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

17527 — MAHMUD, LPN

Witness — Witness

259

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tonoy — 8/27/19
Name of Patient — Date

8270790 ~~1062879 / 4/30/96~~ 8270790 / 7/9/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

~~Prozac tony~~
Aspirin, keppra, Haloperidol, cogentin and Zoloft

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 02/27/19/1820
Date/Time

E/N/G/M — [illegible]
Witness — Witness

25-09

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White - Terry
Name of Patient

2-27-2019
Date

8270790 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500 mg
Haloperidol 10 mg Tablet
Benztropine 1 mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused
Patient Signature

2-27-2019
Date/Time

C171132
Witness

Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Toney — 2-28-19
Name of Patient — Date

8270790 — 7/19/72
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Asprin 81mg, Keppra 1000mg, Haldol 15mg, Cogentin 1mg, Zoloft 50mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 0900 2-28-19
Date/Time

Witness — 8:32

Witness

25-9

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Toney — Name of Patient

3-5-19 — Date

8270790 7-19-72

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Keppra 1000mg, Haldol 10mg, Cogentin 1mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

2000 3-5-2019

Date/Time

17527

Witness

Witness

2J-09

LAS VEGAS METROPOLITAN POLICE DEPARTMENT
CLARK COUNTY DETENTION CENTER

TD
3/7/19

MEDICAL/DENTAL/PSYCHIATRIC REQUEST

Name: WHITE (LAST) TONEY (FIRST) ID: 8270790

Housing: 2J-09 Date of Birth: 07/19/72 Date: 03/05/19

Description of Illness or Injury: I PREVIOUSLY HAD A BLOOD ON CONTACT ALTERCATION AND AM REQUESTING A HIV TEST.

TO BE COMPLETED BY STAFF ONLY

Date/Time Triaged: _____ Category ☐1 ☐2 ☐3 _____ RN

S: _____

O: TEMP: _____ PULSE: _____ RESP: _____ BP: _____

Scheduled for testing

A: _____

B: _____

Refer To: ☐ Sick Call Doctor ☐ Nurse ☐ Psychiatrist ☐ Dentist ☐ DON ☑ Other: _____

Fee Charge: ☐ $ 8.00 Medical Access Fee ☐ $5.00 Medication Fee ☐ $3.00 Medication Renewal Fee

☐ $200.00 or actual cost whichever is higher ☑ No Charge

I understand pursuant to NRS 211.140 that I may be responsible for payment for medical care (see back of this form).

I understand that a Medical Access Fee and/or Medication Fee will be deducted from my cash account.

I understand that fees may be collected at a later date if funds are not currently available. If I do not have sufficient funds to pay and money is deposited to my cash account, the amount I owe for these services will be deducted before any funds are available to me. No inmate will be refused in-house medical services based upon an inability to pay at the time the healthcare is provided.

Inmate Signature: _____ Date: 3/5/19

Staff Signature: _____ Date: 3/8/19 Time: 9:22

INMATE NAME (please print)	ID#:	HOUSING:
TONEY WHITE	8270790	2J-09

DISTRIBUTION: WHITE - Medical Records YELLOW - Inmate

LVMPD DSD 82 (REV. 08-15)

2J

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tony — 3.7.19

Name of Patient — Date

8270790 | 7.19.72

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Asa 81, Keppra 500 mg, Haldol 5 mg, Morphine 1 mg, Septra 1 DS

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

3.7.19 | 0811

Date/Time

0175152

Witness

Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tony — 3-8-19

Name of Patient — Date

8270790 — 7-19-72

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Aspirin 81mg — Benztropine 1mg

Levetiracetam 500mg — Sertraline 50mg

Haloperidol 15mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 3-8-19 0800 Date/Time

Witness — V Banks LPN Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Towey — 3-14-2019

Name of Patient — Date

8210796

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg Haloperidol 10mg Tablet
Benztropine Mesylate 1mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 3-14-19 2000

Patient Signature — Date/Time

Witness — Witness

RJ-9

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Toney — 3-16-19
Name of Patient — Date

7-19-72 8270790
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Haldol 15mg, Asprin 81mg, Keppra 1g, Cogentin 1mg
Zoloft 50mg

JP

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature

0810 3-16-19
Date/Time

8232
Witness

Jaylon Ross
Witness

SUPREME COURT OF THE STATE OF NEVADA

TONEY A. WHITE

Supreme Court No: **78483**

Appellant

E-filed

EXHIBIT 'A' - Part 2

MEDICAL RECORDS FROM CCDC

NaphCare
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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 3/17/19
Name of Patient — Date

827090 — 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

HALDOL 10 mg, KEPPRA 1000mg, GABENTIN (mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

JSMITH 13887 — MOUMAD, LPN
Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 3/19/19
Name of Patient — Date

827079O 7/19/1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

HALDOL 10 mg, DOXEPIN 1 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

Witness — Witness

NaphCare

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White toney — 3-21-19

Name of Patient — Date

7/9/72 8270790

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Keppra 1000mg, Haldol 15, aspirin 81mg
Ciqentin 1mg, Zoloft 50mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — 0800 3-21-19

Date/Time

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Jeremy — 3-23-2019
Name of Patient — Date

8270790 / 07-19-1972
Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Levetiracetam 500mg Tablet, Haloperidol HCL 10mg Tablet, Bowtropine Mesylate 1mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 3-22-18 / 2000
Patient Signature — Date/Time

JTJ12w
Witness

Witness

NaphCare

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

WHITE, TONEY — 3/24/19

Name of Patient — Date

8270790 — 7/19/1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

KEPPRA 1500 mg, HALDOL 10 mg, GABAPENTIN 1 mg

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided NOT to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Patient Signature — Date/Time

Witness — Witness

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RELEASE OF RESPONSIBILITY - SPECIFIC PROCEDURE

White, Tawny — 3-27-2019

Name of Patient — Date

827090 — 7-19-1972

Patient ID Number / Date of Birth

I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations:

Lopetiraceptam 500mg Tablet
Haloperidol 10mg Tablet
Benztropine Mesylate 1mg Tablet

The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

I have decided **NOT** to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.

By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

Refused — 3-27-19 / 2000

Patient Signature — Date/Time

JT RN —

Witness — Witness